

Appendix F Network Health Plan Effective 1/1/09***

19.8.	Appendix F
BENEFIT HIGHLIGHTS	Network (HMO) Benefits
Primary Care Physician (PCP) Office Visit: Preventive Care for children and adults Immunizations Medical Care for Illness or Injury Surgery Performed in the Physician's Office	No charge No charge \$10 Co-pay per visit \$10 Co-pay per visit
Routine Mammograms, PSA, Pap Test	No charge
Specialty Physician Office Visit: Office Visits: Consultant and Referral Physician Services Allergy Treatment/Injections Surgery Performed in the Physician's Office	\$20 Co-pay per visit \$10 Co-pay per visit \$20 Co-pay per visit
Inpatient Hospital Services – Includes Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Inpatient Hospital Doctor's Visits/Consultations	No charge
Outpatient Facility Services: Operating and Recovery Room Diagnostic/Therapeutic Lab and X-ray Physician & Outpatient Professional Services	No charge No charge No charge
Laboratory and Radiology Services: MRIs, CAT Scans and PET Scans Other Laboratory and Radiology Services Outpatient Hospital Facility Independent X-Ray and/or Lab Facility	No charge No charge No charge
Short-Term Rehabilitative Therapy (includes cardiac rehab, physical, speech and occupational therapy)	\$10 Co-pay per visit
Chiropractic Services 20 visits maximum per calendar year	\$10 Co-pay per visit
Prescription Drugs Retail (per 31 day supply): Generic drugs Formulary brand drugs Non-formulary drugs Mail Order Drug: generic, formulary brand, or non-formulary (per 90 day supply)	\$5 Co-pay \$10 Co-pay \$15 Co-pay 2 x the applicable 31 day Co-pay
Emergency and Urgent Care Services: Physician's Office – PCP or Specialty Physician Hospital Emergency Room/Urgent Care Facility Ambulance	\$10 Co-pay per visit to PCP, \$20 Co-pay per visit to Specialty Physician \$50 Co-pay per visit (co-pay waived if admitted) No charge
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities	No charge 100 days combined maximum per calendar year
Maternity Care Services: Initial Office Visit to Confirm Pregnancy All other office visits Delivery Hospital Charges Physician Charges	\$10 Co-pay No Charge No charge No charge
Home Health Services	No charge
Hospice Care Services	No charge
Family Planning Services Office Visits (tests, counseling) Vasectomy/Tubal Ligation (excludes reversals)	\$20 Co-pay per visit \$20 Co-pay

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Infertility Services: Office Visit (Tests, Counseling) Hospital Charges Coverage will be provided for the following services: Testing and treatment services performed in connection with an underlying medical condition. Testing performed specifically to determine the cause of infertility. Treatment and/or procedures performed specifically to restore fertility Artificial Insemination	\$20 Co-pay per visit No charge No charge No charge No charge No charge
TMJ - Surgical and Non-Surgical – case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Physician's Office Hospital Charges	\$20 Co-pay per visit No charge
Mental Health Services: Inpatient Outpatient	No charge \$10 Co-pay per visit up to 20 visits per calendar yr.
Substance Abuse Services	Inpatient -No charge up to 20 days per calendar yr. Outpatient- \$10 Co-pay per visit up to 20 visits per calendar yr.
Durable Medical Equipment/External Prosthetic Appliances	No charge
Vision Care Eye exam Exam Frequency Under age 19 – limited to one exam every calendar year Age 19 and over – limited to one exam every two calendar years Hardware	\$10 Co-pay per visit One exam every calendar year One exam every two calendar years \$100 every two years for each member
Health Club/Equipment Reimbursement NOTE: This is a Taxable Benefit	The cost of approved Health Club membership up to \$450 per employee or up to \$200 reimbursement for approved exercise equipment
Annual Deductible Individual Family	None None
Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs Individual Family	\$500 \$1,000
Annual Out-of-Pocket Maximum (OOPM) for covered medical costs** Individual Family	\$ 500 \$1,000
Lifetime Maximum	None

*Deductibles apply **Credits toward the in-network OOPM accrue separately from credits toward the out-of- network OOPM

***Current plan design (as of 6/30/07) remains in effect until 1/1/09. The co-pays referenced herein become effective 1/1/09.

Benefit Maximums apply to in-network and out-of-network combined.

All out of network services limited to reasonable & customary limitations

Benefit Exclusions:

Your plan provides coverage for medically necessary services only.